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AUGUST-SEPTEMBER
1951



KATHARINE F. LENROOT RETIRES FROM THE CHILDREN'S BUREAU

Martha M. Eliot, M.D., Succeeds Her

AT HER REQUEST, President Harry S. Truman has accepted Miss Lenroot's resignation as Chief of the Children's Bureau, to take effect on August 31, 1951.

In retiring from this position, Miss Lenroot says she needs some leisure, some time to read and to use for activities that have been crowded out of days dedicated to making this Bureau an effective instrument of the people for serving children. No one can begrudge her the leisure she has so rightly earned. But the Bureau staff, and thousands of other people who have worked with her, will miss the inspiring guidance and tireless help that she has given them for so many years, ever since she joined the Bureau staff in 1915, became Assistant to the Chief in 1922, and especially during the 17 years she has been Chief.

Many honors have come Miss Lenroot's way and many responsibilities have been laid on her during her 36 years with the Bureau. She was President of the National Conference of Social Work in 1935; Chairman of the U. S. Delegation to the 5th, 6th, and 9th Pan American Child Congresses; President of the Eighth Pan American Child Congress; U. S. Representative on the Advisory Committee on Social Questions of the League of Nations; Adviser to the U. S. Government delegates to the International Labor Organization Conference in 1945; Adviser to the U. S. Delegation to the Inter-American Conference on Problems of War and Peace in 1945; U. S. Member of the Executive Board of the United Nations International Children's Emergency Fund since 1947. Holder of the Rosenberger Medal from the University of Chicago, the Gold Medal of the National Institute of Social Sciences, and the Survey and other Awards, she has been awarded honorary doctoral degrees by Wisconsin, Tulane, and Western Reserve Universities and from Russell Sage College.

The Children's Bureau staff salutes a valiant and devoted spokesman for children here and around the world, and welcomes as her successor our long-time friend and former Associate Chief, Dr. Martha M. Eliot, whose nomination by the President was confirmed by the U. S. Senate on July 24, 1951.

June 22, 1951

Dear Mr. President:

I hereby request retirement from the Federal service as Chief of the Children's Bureau, effective September 1 or as soon thereafter as arrangements can be made for my successor to take office.

It is, indeed, a hard decision to make to leave the Children's Bureau, with which I have been associated throughout almost my entire working life. In the 36 years in which I have been a member of the staff, great advances have been made in maternal and child health, child welfare, and child-labor protection. The Bureau has played a significant part in these changes through research, dissemination of information, cooperation with the States in grants-in-aid, establish-

ment of Federal child-labor standards, and development of methods of co-operation with citizens in behalf of children. It has shared with other nations knowledge and experience relating to child life. The Midcentury White House Conference on Children and Youth served to broaden our understanding both of the importance of going forward in extending and improving services to children, especially in this critical period of world history, and of the need for much more extensive research. I am grateful, especially, for your sponsorship of the conference and the great contribution you made to its success.

In laying down my task, because I have reached the age when I must have more leisure, I am confident that with your understanding and sup-

port of its program, the Children's Bureau, with its broad concern for children and youth, will be given still greater opportunity to serve our country and the children who are its future.

Respectfully yours,

Katharine F. Lenroot

July 9, 1951

Dear Miss Lenroot:

With real regret I accept your resignation as Chief of the Children's Bureau of the Federal Security Agency effective at the close of business on August thirty-first next.

You have been in Government service for 36 years, and for the past 17 years you have headed the Children's Bureau. That is a long tenure of office for any public servant. But it is especially significant because you have been one of that small and select group of women who have risen to high public office through merit and determination. Best of all your service has been as distinguished as it has been long-continued.

Toughness is a quality not often attributed to women but the plain fact is that you have been a tough and persistent champion of America's children. You have made them both your vocation and your avocation. The children of this country are better off for your having been in the Government. What greater satisfaction could anyone take into retirement?

Although you will soon retire to a well-earned rest, I hope that from time to time I shall have the chance to look to you for advice and help in matters affecting the children of America. I know that you will never relinquish your interest in their welfare as long as you live.

With warmest good wishes, I am
Very sincerely yours,

Harry S. Truman

RHEUMATIC FEVER AND THE CHILD'S EMOTIONS

BETTY HUSE, M. D.

RHEUMATIC FEVER, like any other serious or long-drawn-out illness, is sure to have some effect on a child's emotional development. It affects this development differently in different children. What it does to a child depends on what his experience with the illness means to that particular child.

Of course, the child's experience with rheumatic fever will depend partly on how severe his attack is, what his symptoms are, how long he is sick, and what methods of treatment are used. Rheumatic fever may attack the child's joints, his nervous system, his skin, or his heart. The severity of the disease varies, too. One child may have a high fever and painfully swollen joints. Another may have pains in the joints so mild that he goes about his usual activities without realizing that he is sick. The child is usually sick with rheumatic fever for a long time—often for many months.

What is his emotional background?

But the child's experience will depend in large part on what kind of child he is and on what has happened to him in the past. It will depend on the kind of body and mind he was born with; on how old he is when he gets rheumatic fever; on his relationships with his father and mother; on how he gets along with his brothers and sisters and other children; on his previous experiences, good and bad; and on his general pattern of coping with his problems. And, because a child is so much influenced by his parents, it will depend too on how the parents feel about the disease.

What are some of the factors in rheumatic fever that are likely to affect the emotional development of a child who is attacked by this disease?

Since few children under the age of 3 years get rheumatic fever, we



Every child has his own worries, and the child with rheumatic fever has plenty of them.

must realize that as a rule the child who does get it has already developed some of his fundamental emotional structure. But much of his development is still to come, and the disease may retard or distort it.

Death is a real possibility in rheumatic fever, either early in the acute stage, or at some future time if the

Dr. Huse is Pediatric Specialist in the Program Planning Branch of the Division of Health Services, Children's Bureau. She is a pediatrician who has spent a good portion of her professional life working on the problems of rheumatic fever. Among her jobs in the Children's Bureau has been consultation to the States on programs for the care of children with this disease.

This article is based by Dr. Huse on a paper that she prepared for the Midcentury White House Conference on Children and Youth. The paper is one of a number that served as resource material for the Fact Finding Report of the Midcentury White House Conference on Children and Youth, which is to be published in the fall of 1951. The procedures of the conference did not provide for official approval of these papers. Address inquiries to National Midcentury Committee for Children and Youth, FSA Building, North, Fourth and Independence Avenue, S. W., Washington 25, D. C.

disease gets worse. A young child may not have a clear idea of this, but he may reflect the fear shown by his father and mother. Older children more often than we imagine become aware of this possibility through what they overhear and guess, and they may be very frightened. A frightened child may even convince himself that he is not sick and refuse to do the things that would help him get better.

A sick child, like any other sick person, tends to go back, at least temporarily, to his earlier ways of behaving. Some of the child's earlier patterns of behavior, such as bed-wetting, thumb-sucking, babyish eating habits, and depending too much on his mother, may worry his parents. And often the more the parents worry, the more babyish the child gets. If his babyhood or early childhood gave him more satisfaction than his present time of life, or if he had problems earlier in life that were never quite solved, it may be hard for him to get back to acting his age. Sometimes, on the other hand, a successful encounter with

an illness seems to lead to a real spurt in emotional development.

Often a child does not understand the real purpose of a medical procedure, and attributes to it a purpose that is connected with his own imagination and inner life rather than with reality. Blood transfusions, blood-pressure recording, needles, taking of rectal temperatures, oxygen tents, X-rays, fluoroscopes, and so forth, may be interpreted in bizarre ways. The child may think that people really want to injure him, or that he has earned this treatment as punishment.

In the early stage of the disease the child is almost completely dependent on his mother or a nurse. He is fed, put on a bedpan, given a bath in bed, lifted from one position to another. This physical dependency may be unwelcome to some children, welcome to others. One child may deal with it by outright rebellion; another may enjoy it and not want to give it up.

Often a child with rheumatic fever must be taken from his home to a hospital or a convalescent home. Separation from the parents may be a great shock for the preschool child, and the effect of this shock may seriously interfere with his ability to form emotional relationships with people later in life. It is usually less serious for the child from about 6 years to the beginning of adolescence, but may still be very hard for some children. For an

adolescent, separation from his parents may stir up latent emotional conflicts having to do with the adolescent's attempt to become more independent of his parents.

The child with rheumatic fever may at some point in his treatment be separated from other children of his own age. If this separation lasts a long time, as it may, the school-age child may be slowed up in developing relationships with other youngsters of his age. The adolescent may suffer acutely since he depends so much on others of his own age in his struggle for independence, for recognition as an adult man or woman, and for a firm set of values for himself.

When a little child, 3 to 6 years of age, is obliged to stay quiet in bed, he is kept from his natural ways of blowing off steam.

For the older child such restriction keeps him from playing with his friends. And it may mean interference with types of play that are important to his emotional development. It may also mean interference with schooling, which is so important as a way of learning to understand and deal with reality. It may interfere with creative activities, such as art and music, and thus interfere with a good method of dealing with emotional problems.

It is true that the heart is generally affected in rheumatic fever, and that actual infection of the

heart may cause heart failure and even death during an acute attack. However, the scarring of the heart known as rheumatic heart disease, which may remain after the acute attack has passed, should not as a rule interfere with the child's life, though an occasional child is left with handicapping heart disease.

Even though fear of handicapping heart disease is usually unfounded, many parents, and even the children themselves, are worried and afraid about the future. A young child may reflect his parents' fears, but an older child or an adolescent may himself be frightened about what may happen to him. The adolescent may have real worries about the possible effect of his heart disease on his prospects for earning his living and for marriage and having children.

Mother and father worry, too

The reaction of the mother and father to the illness of their child may be very complex. There will usually be real fear; there may also be anxiety related to the parents' own emotional reactions to the idea of illness and possible death. The parents may feel guilty for a variety of reasons. They may blame themselves on the ground that the child may have inherited the disease; or they may feel that they have given the child inadequate care before the illness. (Either of these ideas may have been suggested to them by neighbors or by something they have read.) Or they may without knowing it blame themselves for hostile thoughts they have had about the child from time to time or for past deeds they have on their conscience.

At the beginning of the illness the mother will usually throw herself into the care of the child at a pitch that she cannot possibly keep up as the disease drags on. The dependency of the child and the needs for restricting his activity may be welcome to the parents, or it may be almost unbearable to them. The time and attention that the mother gives the child, and her attitude to-

This little girl, with an attack of rheumatic fever, had to go to the hospital for treatment. At this age, separation from her mother and father is likely to be a great shock to her.



(Continued on page 11)

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TO STRENGTHEN MATERNITY-HOME SERVICE FOR UNMARRIED MOTHERS

JANE E. WRIEDEN

DURING the long history of maternity homes for unmarried mothers, such homes have on the whole progressed greatly in both policies and practices. But not all the homes have changed enough to meet modern standards. And even the best of them could further improve their services.

Improving this form of social service is a complicated task. The homes need the skills of the obstetrician, the pediatrician, the psychiatrist, the nurse, the case worker, the group worker, and the psychologist. This is because the problems in a maternity home usually have grown out of a young woman's confused relations with other people, her lack of understanding of herself, and her immediate need of medical and nursing care in a sympathetic atmosphere. The lifelong health and happiness of the mother and child are the aim of the service. Whatever is best for each one of them is planned for and worked toward; in the process all phases of life may be touched on.

Homes and agencies supply facts

As a step toward finding out how far we have progressed in improving these homes and how much we still have to accomplish in making them as useful as possible to unmarried mothers and their babies, I asked some questions across the country about the services. I sent out 235 letters in January 1951, to a number of maternity homes and to a family agency and a children's agency in each State. (All of the social agencies were members of either the Family Service Association or the Child Welfare League of America.) Thirty-two of the maternity homes and 63 of the social agencies sent me the needed infor-

mation. I also studied the standards that several States have established for licensing and supervising maternity homes. I talked with a number of unmarried mothers to get their opinions on how homes could be improved. As a result, I find that I can generalize as follows:

1. All who work with unmarried mothers are much more aware than before of the complexity of the problems these mothers must solve. All are anxious to raise the standard of services available to her for herself and her child, especially the standards of maternity homes.

2. Maternity-home service has developed unevenly in different parts of the country, in cities large enough to have several homes, in agencies operating a network of homes located in different States, and in agencies operating several homes in the same State.

3. The essentials of good maternity-home service, all of us agree, are: A good staff capable of giving case work, group work, medical and nursing service; housing and other facilities that are adequate; and funds that are sufficient. But we differ on three points: What is meant by "good," "sufficient," "adequate"; what constitutes case work, group work, and the right amount of nursing care; and *how* to achieve

Jane E. Wrieden, a major in The Salvation Army, has been on the Army's staff for over two decades. In order to get graduate education in social work, Major Wrieden took time off from her duties. She gained her degree from the School of Social Work of the University of Buffalo. She has been director of the Salvation Army Home and Hospital, in Jersey City, N. J., a home for unmarried mothers, for 4½ years.

This article is based on a paper that Major Wrieden gave at a meeting of the National Committee on Service to Unmarried Parents, which was held in association with the seventy-eighth annual meeting of the National Conference of Social Work, convened at Atlantic City, N. J.

our objectives.

4. Not all homes have policies based on today's knowledge. We need more study in order to decide what our aims are and to clarify our methods of work. Besides the gaps that are apparent in what we know there are gaps between what we know and what we do.

5. Our maternity homes are not reaching all unmarried mothers who could use the service to advantage. We have not even scratched the surface of our task of building a public-information program that will get information to all the girls who need us and that will carry the interest of the civic-minded people of a city along with our work.

6. A national code would be valuable, a statement of the principles underlying maternity-home service, from which each home could develop sound policies and practices suitable to its own work.

If we are to accomplish the changes indicated by these six points, we have to begin somewhere. This beginning is what we are considering here.

A sound philosophy and clear, definite policies should result in practices of high quality. If the service of a maternity home grows out of concern for the well-being of an individual, based on respect for the dignity and worth of all individuals; if we are committed to democratic ideals and practices; and if we recognize the primacy of spiritual values, then we have a sound philosophy. Our practices will reflect this acceptance of individuals as they are, our wanting to understand their problems and to be permissive and flexible in dealing with them; our keeping their confidences inviolate; and our giving them freedom within broad limits that are acceptable to them.

The maternity home is a home even though a temporary one; its

setting should be as normal as possible. Any policy that imposes restrictive living conditions, or that implies that a resident does not have freedom of decision in the home is indefensible.

A place for self-discovery

We should examine what we mean by some words we use frequently, such as "secrecy," "seclusion," "protection," to decide whether the practices implied are in harmony with our philosophy of today. The maternity home should not be, as it was in its early history, merely a haven, a refuge, or a place of escape, though it does offer privacy and confidential services. It is a place for helping an individual rather than a place for overprotecting her, patronizing her, or punishing her. It is a place where love and freedom can be given to the residents but in a way to spur an appreciation of their personal responsibilities and of the rights of others. It is a place for self-discovery, not for indoctrination, a place where the person and the group may grow in insight through helpful experience. The treatment given takes into consideration everything that has happened to the girl, not only her pregnancy outside of marriage, which may well be a symptom of something deeper. The treatment is to meet whatever needs the individual has—the emotional, physical, economic, educational, recreational, or spiritual needs.

This philosophy will be effective only if our practices are flexible. We must be open-minded about such points as these: The time during pregnancy that we admit an applicant and the length of her stay; the whole question of fees; persons to whom the service is offered (for example, to a woman who has some physical ailment such as a venereal infection or epilepsy, or to a married woman who is illegitimately pregnant, or to a woman who has been pregnant before). Our practices must be flexible in regard to the mother's decision about whether or not to see her baby after his birth if he is to be placed for adoption; about whether or not to feed him



The lifelong well-being of both mother and child is the aim of good maternity-home service.

at the breast; about group activities; about a resident's attendance at religious services; about her visiting in or outside the maternity home, as well as about house routines in general. Rigidity of practice has no place in services to human beings. Frequent review and revision of policies and practices as a result of staff experience should lead to the needed flexibility.

But flexibility must fit into the framework of reality—the reality of the resident's rights, the group's rights, the home's limitations, and the community's limitations. However, let us be careful not to use these realities and limitations as convenient pegs on which to hang our own unresolved conflicts, such as whether or not to give service to Negro girls who would benefit from maternity-home care. We should remember that courage to lead a community to rid itself of a limitation that denies rights to some of its people is part of the tradition of our field of work.

Good policies and practices decided upon can be carried out in the home only if good case work, group work, and nursing care are available. A spot check was made last year in one State by a com-

mittee of social workers to see what maternity-home policies and practices were in use. The check disclosed that although maternity-home service had improved to a certain extent in that State, there were still wide gaps between philosophy and practice; that some service was "rigidly religious," and focused on controlling rather than helping the resident; that some required the mother to stay as long as 6 months after the birth of her baby. Some homes, the report stated, could give better services, especially at the time of the mother's separation from her baby and in the period after her discharge from the home.

This illustration of the result of insufficient help was given: A girl of 18, who had decided to relinquish her baby for adoption, was required by the maternity home to keep him with her for 3 months before their separation. Although caring for him made giving him up very difficult, the mother did not receive the help she needed for herself in order to feel sure that she had made the best decision about her baby. She went ahead with the adoption; but 7 years later, when she was about to marry, she seemed

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to show the results of this lack of help. She rented a safe deposit box for the sole purpose of keeping a picture of her baby where no one could see it, and went to the box every 2 weeks to look at the picture. If she had had the right kind of help early and if this help had continued as long as she needed it, she might have been spared this emotional conflict about having given up her baby.

If a maternity home intends to fulfill all the needs of an unmarried mother—emotional, physical, educational, and spiritual needs—and is without social case work, this lack is as illogical as if it had no nursing care. It is my firm belief that the case worker in a maternity home should not only have had full graduate education in an accredited school of social work, but should also have had experience in a case-work agency of high standards, before she joins the staff of the maternity home. Unfortunately, these homes, even today, tend to permit a person who lacks professional education and experience to act as a case worker and to expect her to do a professional job.

Case work is the core of help

Social case work is not something to be tacked onto a program. It is the heart of the maternity-home experience. This experience begins when a young woman first reaches out for help by means of a letter, a telephone call, or a visit to the home. The importance of what happens to her in the early stages of application cannot be stressed too much. Even the kind of stationery we use (plain, informal), the friendly tone of our letters, how promptly and graciously we answer the telephone—all these mean much to the applicant. This asking for help arouses deep feelings, perhaps of guilt and unworthiness, or of fear that help will be refused. Some girls tell us, "I'd been trying so long to find a place to go." For many girls—especially Negroes—this experience of seeking help is extra difficult—they have so far been unable to find a maternity home "that will take a colored girl."

In this early stage, the case worker helps the applicant to learn about the various services available; that is, what the alternatives are, what group living consists of, what she can expect of the maternity home, and what the maternity home will expect of her. Through this early contact and through close relations that follow, through what the case worker accomplishes for the young woman with other members of the staff and with her family and others concerned, the case worker helps the client get into focus the picture of what has happened. The worker can make psychiatric and psychologic help available as the worker and the girl continue their contact through the girl's period of adjustment to the group in the home, of her waiting for the baby, of his birth, of deciding about his future, of the separation from him if the mother decides the baby should be adopted. The worker helps the girl when she is leaving the maternity home and is returning to her normal pursuits. The help continues until the time when the client no longer needs the case worker's assistance.

How can a maternity-home ad-

ministrator feel competent to help a young woman successfully through such an experience without having the services of a qualified social case worker? To that question my own answer is simple. I, for one, would not.

The help that these specialized services can give is illustrated by what they did for Miss Z, one of the many young women I have worked with in a maternity home. As she later put it, she came in with a chip on her shoulder and with two strikes against her—"I'm pregnant and I'm colored." She was polite but hostile, always ready for a showdown. But Miss Z got a great deal from her experience in the home. She was helped by her regular interviews with the case worker and by the conferences the worker had with other staff members to help them understand the meaning of the girl's behavior, and by a psychological evaluation of her aptitudes. She had decided to give the baby up for adoption, and so the worker arranged for her to go to an adoption agency. Afterward, with deep feeling, she told the case worker at

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A well-run maternity home will provide health supervision, at the home or elsewhere.

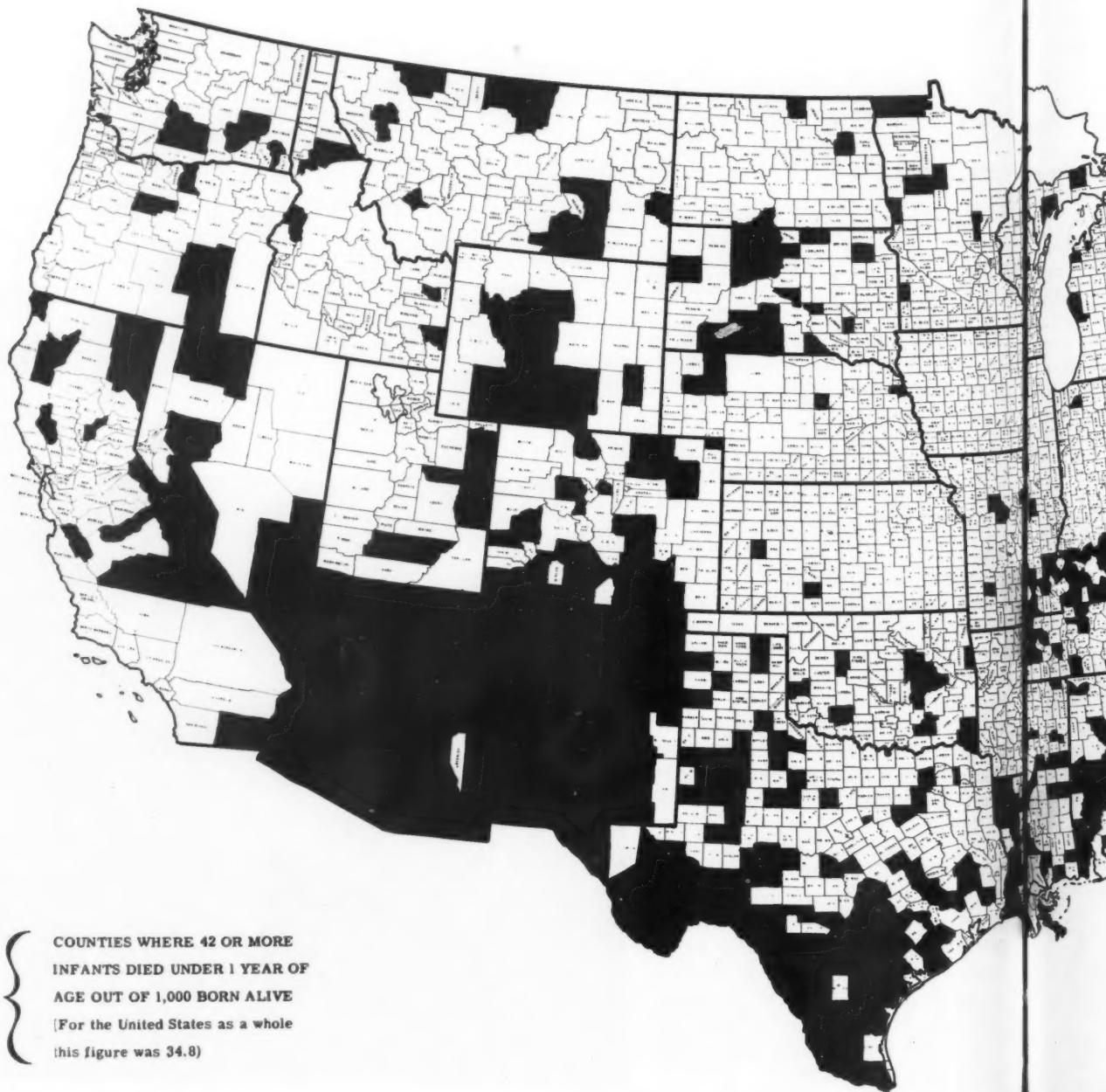


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THERE'S A BIG JOB STILL TO DO

THESE U. S. COUNTIES HAVE THE HIGHEST INFANT MORTALITY RATES



WHAT DO TO SAVE INFANT LIVES

INFANT MORTALITY RATES — 1944-48



In the United States as a whole the mortality rate among babies less than a year old has been going down for three and a half decades—from 100 deaths per thousand live births in 1915 to 29 per thousand in 1950 (provisional figure).

But many localities of the country still have high rates. The map on the left shows that nearly a quarter of our counties had an infant mortality rate of 42 or more during the 5-year period 1944-48, the latest 5-year period for which we have final figures for counties. Many of the shaded counties on the map join to form regional patterns, or high infant mortality rate areas, cutting across State lines.

If, in 1944-48, these counties had as low an infant mortality rate as the United States as a whole, the lives of about 40,000 babies would have been saved during those 5 years.

The problems connected with saving babies' lives are more than medical. They involve low incomes, poor sanitation, and habits of people. Often the area of high infant mortality is chiefly rural, and the people affected may be minority groups such as Indians, Negroes, or Spanish-speaking Americans.

These people need more doctors, nurses, nutritionists, and medical social workers, who know the special problems of these minority groups and can work effectively with them. They need, too, help in getting better sanitation and other health safeguards.

They need, most of all, a comprehensive attack on the problem, with Federal, State, and local governments and voluntary agencies cooperating in the work.

NURSERY SCHOOL CAN HELP CHILD'S SPIRITUAL GROWTH

RUTH TAYLOR STONE

HOW CAN WE lay foundations within the understanding of little children—3, 4, or 5 years of age—for spiritual growth, for faith in God as God comes to have meaning to them, and for joyous fellowship with others?

This is the type of earnest question that was discussed by a group of Sunday School teachers and directors of religious education in a 6-week evening extension course last winter at Boston.

The course was sponsored by several New England denominational groups and was led by a representative of the Nursery Training School of Boston. Fifty teachers from Boston and its suburbs brought their problems, many of which seemed difficult at first, but which proved, as the meetings progressed, in not a single case impossible to solve.

Problems of space and equipment, of how to teach, of how small children learn, of how to interpret a religious program to parents and officials led the members of the group to visit carefully selected weekday nursery schools and kindergartens.

Spiritual awakening comes early

They found that these children were learning the first principles of religion as they played with their friends, under wise guidance, gathered in small groups for a short story, or as they felt the soft petals of early spring forsythia, which had been unfolding day by day before their eyes.

For better teaching of religion we need to know more about child de-

velopment, the teachers agreed. The little child must be given a setting in which he can be himself and learn at his own level. He needs space to move about freely, and he needs familiar play materials to experiment with and to share with his friends. He is full of the excitement of growing, is fascinated with learning all sorts of things, and is eager to learn; but he must learn in his own way.

The group realized that it is only too easy for a teacher of young children to try to teach religion without realizing the subtle ways in which the concept of God and of our share in God's world is developing in the child. The bursting buds in the springtime and the changing colors of leaves in the fall, the snow crystals under the magnifying glass—even a very young child can be helped to see that here is a power far beyond that of the heretofore all-powerful parent. These, the group felt, are worship experiences at the child's level; and from them will grow a concept of a divine being present in all life, in all activity, in all creativity.

The energy that makes it impossible for a 5-year-old to sit still

and memorize a psalm can be used to make a bird-feeding station so that a fellow creature will live through a long winter, the teachers were reminded. Children learn with their whole selves. They can learn, and enjoy learning, principles of right and wrong. They can understand the behavior of the good Samaritan and imitate it, even though they may not yet be verbal enough to cope with formal prayers. The teacher needs to be alert to simple worship experiences that develop naturally as the children live and play together. And a good teacher knows that a long period of sitting quietly in a large group and being taught is unnatural to the little child. That is not his way of learning, and he will merely become bored and restless.

A good nursery school or kindergarten, it was agreed, endeavors to foster a friendly, cooperative atmosphere, in which children may grow into life with faith in themselves and their place in God's world. A good teacher not only finds sufficient space for active bodies and provides opportunities for wholesome play, with sturdy, well-chosen materials; she creates an atmosphere that is conducive to righteous living.

In such a class, the group agreed, strong and permanent foundations are laid for a child's religious growth.

Reprints in about 6 weeks

Observing the wonders of nature, little children can learn the first principles of religion.



Ruth Taylor Stone received her master's degree at Boston University School of Education. She is also a graduate of the Nursery Training School of Boston and is a member of its staff. She was for many years director of a private nursery school in a Boston suburb, and she devotes her spare time to parent education.

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RHEUMATIC FEVER

(Continued from page 4)

ward him, may create conflicts between the parents.

All these reactions of the parents will be bound to affect the parent-child relationship one way or another, and thus may affect the child's emotional development profoundly, especially if the child is young.

As rheumatic fever affects each child in an individual way, so the method for dealing with the emotional effects of the disease must also be individualized, and based on understanding of the meaning of the experience to the individual child. The only thing that could help everyone would be a sure, fast cure of the disease.

Meanwhile, however, something can be done in relation to the child, his parents, and the personnel involved in treatment:

1. For the child—It is important that attention be given at every step to his potential emotional problems. It will help if the child is given an opportunity to talk about his fears and his angry feelings and to tell as much as he can about how he feels about his illness. Allowing him to take some active part in managing the situation is usually helpful. The small child may be given a chance to choose, for example, whether he gets his medicine straight or in applesauce, and to make similar decisions within the limits of the medical treatment that is required; an older child may be given some responsibility for more important decisions. Although the child may be expected to act younger than his age at the beginning of his illness he should be helped to return to more grown-up ways as soon as this is feasible, by encouraging him to take increasing responsibility. If he is restricted in his physical activity, the limits of these restrictions should be made very clear to him. He should be treated consistently. He should be prepared for new experiences insofar as possible by clear and true explanations. He should be given op-

portunities for play, schooling, and creative activities consistent with his physical condition, his age, and his interests. Separation of the child from his parents should be regarded as a serious step; and the decision to send a young child to a hospital or convalescent home should be made only if treatment in his home is impossible. An adolescent, on the other hand, may be able to get through his illness and convalescence better when he is cared for with a group of others of about his own age.

2. For the parents, too, much can be done. They should have opportunities for a careful and realistic discussion of the medical situation and the probable outcome of the illness. They should be encouraged to talk about their worries. They should be helped to see whether they are being unnecessarily indulgent or strict. And they should be helped to understand what their child is feeling and what he is worrying about, and how they can best give him support in this difficult situation.

3. The personnel involved in the treatment of the child can help greatly if they do their utmost to be consistent; if they can accept hostile or fearful attitudes on the part of the child or of his parents; if they consider every procedure in the light of the emotional as well as the physical effects and if they minimize emotional hazards by explaining the procedures to the child so far as is feasible, by eliminating unnecessary procedures, and by providing substitute outlets for his feelings when possible; if they watch the child's emotional condition in relation to his age and previous level of development; if they are as definite as possible about restrictions and drop them as soon as it is medically safe to do so; if they consider the child's emotional as well as his physical needs in planning for a period of separation from his parents; if they discuss his emotional problems with a psychiatric consultant and request consultation when this is needed.

Reprints in about 6 weeks

UNMARRIED MOTHERS

(Continued from page 7)

the home about her interview with the adoption worker; it was another step forward in the self-discovery she was going through in the maternity home.

Group work adds its therapy

All this (and much more of course) is what I mean by social case work—what I mean by saying that case work is the heart of the experience young women have in a good maternity home. In such a place a resident may know the graciousness of home life, the reality of spiritual values and of democratic ways; the richness of interfaith and interracial living. Some maternity homes have "residents' councils" in which the girls themselves discuss group living and set their own standards for it. How residents use the group experience depends partly on the stimulus they get. This does not mean a leader "doing for" the group, or volunteers from outside coming in to put on programs for the "in group." At its best, it means getting help from a professional group worker, who is, preferably, a member of the maternity-home staff, and who works with the group to help it make its recreational plans and to carry them out.

Small groups may be formed voluntarily for various recreational and craft activities. Girls may choose to make ceramics or hand-sewn gloves, to learn dressmaking, or work at oil painting. They may form camera clubs, gardening clubs, or discussion groups. In all the groups, the group worker should have the role of helper. Not all the activities are in the home. The young women, often in small groups, seek recreation outside—movies, concerts, walks, trips—maybe visits to the circus or to a museum. Some homes have found that their residents get a great deal from visiting cathedrals and other churches.

The work of a maternity home—housekeeping, maintenance, laun-

IN THE NEWS

dry, and food services—is an important part of group living. Consider, for example, the contribution that nutritious, attractively served meals make to the well-being of residents and staff. Furthermore, it is necessary for the staff to understand what food can mean to a person psychologically; much has been learned in the psychiatric field about this. The question is often asked whether a resident should or shouldn't help with cooking and serving meals and the other work. That question should be, rather, whether the household tasks she does are helpful to her, taking their rightful place in the whole experience she has in the home.

In homes where religion is an inseparable part of the group life, groups may be formed for various kinds of devotions, but attendance should be by choice. Religion should not be something added to the program, but rather interwoven through all that is done. If it is, it is felt in the philosophy, the policies, the atmosphere of the home; in the relations between staff members, residents, and workers from other agencies to the extent that the clients may feel a deep faith, expressed in daily living.

For the health of all in the home

The health services in a maternity home should, of course, be properly staffed and should be welded with the other services. The health program should include services for staff members.

Some maternity homes do not have a hospital within their walls but arrange for obstetric service in community hospitals. If this service is given in the home, it should be given by a medical staff appointed annually by the board of directors on the basis of full knowledge of the staff's qualifications. The medical staff should be well organized and should meet regularly to review the medical care in the home.

(To be concluded in the October issue)

White House Conference. The National Midcentury Committee for Children and Youth, a new committee whose job is to give national leadership in carrying out the objectives of the Midcentury White House Conference on Children and Youth, has been organized in accordance with the resolution on the follow-up program adopted in December 1950 by the 4,636 delegates to the conference.

Leonard W. Mayo, director of the Association for the Aid of Crippled Children, former president of the Child Welfare League of America, and chairman of the executive committee of the conference, has been elected chairman. Elma Phillipson, White House Conference consultant on participation of national organizations, has been appointed executive secretary.

Members of the new committee represent all parts of the country and many backgrounds of experience in work with children and young people. All serve as private citizens. Among the members are persons who were on the National Committee for the conference or on one of the three advisory councils—on State and local action, on participation of national organizations, and on youth participation.

The committee's relationships with Federal agencies will be maintained through five liaison representatives designated by the Inter-departmental Committee on Children and Youth to serve without vote. Those designated are: Katharine F. Lenroot, Children's Bureau, and Bess Goodykoontz, Office of Education, both of the Federal Security Agency; Henry L. Buckardt, Department of Defense; Mrs. Callie Mae Coons, Department of Agriculture; and Beatrice McConnell, Department of Labor.

In the 6 months following the conference, thousands of meetings were held to explore the implications of conference findings and to establish priorities for achieving conference goals; "Little White House Conferences" met in more than half the States; conference findings were studied by many national organizations; hundreds of articles appeared in popular magazines, professional journals, and newspapers. The Pledge to Children and other conference materials were widely reprinted throughout the country.

The National Midcentury Committee's program is designed to achieve the basic objective of the White House Conference—a fair chance for the healthy personality development of every child and young person. In line with this objective, it is recognized that citizens everywhere must continue to work toward strengthening and conserving family life amid the stresses of defense.

An important step that citizens can take in this direction is to join increasingly the planning, developing, and carrying out of programs for advancing the well-being of all the Nation's children and youth. State and local committees are a fruitful means of providing channels for increased citizen participation. Full cooperation of national organizations is essential. One of the committee's primary objectives will be to work toward ways of providing increasing opportunities for young people to participate in all appropriate aspects of community life.

The committee recognizes that, in accordance with the conference resolution on the follow-up program, "the chief operating groups upon which the responsibility for follow-up should fall will be existing organizations—National, State and local." To these the committee is offering the assistance of a small central staff to provide field service to State committees and national organizations and an information service on materials and media of mass communication.

National Commission dissolved. The National Commission on Children and Youth, appointed in 1946 by its chairman, Leonard W. Mayo, and the Chief of the Children's Bureau, Katharine F. Lenroot, has been dissolved as of July 9, 1951.

At its February 1949 meeting, the commission decided that the question of continuance of such a body should be considered in relation to the follow-up of the Midcentury White House Conference of Children and Youth, which met in December 1950.

This spring the commission's executive committee decided that with the organization of the National Midcentury Committee for Children and Youth to foster the follow-up program, the functions of the com-

mission would be in large measure performed by the new committee.

The National Commission on Children and Youth, since 1946, has given active leadership in planning programs for children and youth. Its reports, adopted at meetings in December 1946, January 1948, and February 1949, highlighted progress and pointed out areas in which further action was needed. Over 15,000 copies of its 1949 report, *Moving Ahead for Children and Youth*, were distributed. This report, which embodied the program of the commission, noted action needed in behalf of children and youth in fields such as adequate family income, good housing, health services and medical care, mental health and guidance services, educational opportunities, recreational services and facilities, educational and vocational guidance and placement services, social services, and legal protection for children and youth.

The National Commission in 1946 proposed the holding of a 1950 White House conference on children. It sponsored the March 1948 Conference on State Planning for Children and Youth that developed suggestions for State and local action in preparation for the conference. It participated with the Interdepartmental Committee on Children and Youth (Federal) in a Joint Interim Committee that advised on early preparatory activities. Several commission members were named as members of the National Committee for the Midcentury White House Conference on Children and Youth appointed by the President in August 1949, and others participated in the committees and advisory councils that worked with the National Committee. All members of the commission were invited to the conference; and many attended and took active part as speakers, leaders, and members of work groups.

The secretary of the commission submitted a final report on its action program, pointing out the many advances made between 1949 and 1951 on measures advocated by the commission.

The National Commission on Children and Youth succeeded the National Commission on Children in Wartime, appointed in 1944, which in turn had taken the place of the Children's Bureau Commission on Children in Wartime, appointed in 1942.

Included in the membership of each of these commissions were representatives of national organiza-

tions and professional associations and selected State and local leaders working in behalf of children and youth.

Day-care centers. For every child now in a day-care center, there is one or more on a waiting list, says the Child Welfare League of America. A sampling in eight cities, made by the League, discloses that applications for day-care services for children of mothers who are employed increased over a period of 5 months at rates ranging from 10 to 166 percent.

Dallas, Tex., reported an increase of 20 percent; Jacksonville, Fla., 25 percent; Fort Wayne, Ind., 30 percent; Minneapolis, Minn., 50 percent; St. Petersburg, Fla., 80 percent; Denver, Colo., 100 percent, and Lowell, Mass., 166 percent.

Atlanta, Ga., reported the smallest increase in these applications for day care (10 percent), though its center caring for Negro children reported an increase of 100 percent.

The League hopes its report will stimulate other cities to make studies of their own to find out how many children now need this type of care, and how many will be needing it in the immediate future.

Schooling for mentally handicapped. Implications for State and local school systems of the movement to establish day-school classes for severely mentally handicapped children were discussed at a conference held June 11-13, 1951, at Washington, under sponsorship of the Federal Security Agency's Office of Education. The conference was conducted by Arthur S. Hill, Chief of the Section on Exceptional Children and Youth, of the Office of Education.

Organizations represented included the National Association of State Directors of Special Education (representatives came from six States), the American Association on Mental Deficiency, the International Council for Exceptional Children, and the Federal Security Agency.

The discussions took into account the fact that legislation in a number of States, making such classes mandatory or permissive, has focused the thinking of educators and public welfare agencies upon a clearer identification of the problem of the need of mentally handicapped children for schooling; upon a formulation of objectives in establishing day-school services for such children; and upon consideration of what experiences would constitute

an adequate program for children who are not adaptable to ordinary special-class programs.

It is expected that one outcome of the conference will be publication of a bulletin that will discuss these and other factors involved in providing for the needs of the more severely retarded who can be assisted through the establishment and maintenance of day-school services.

Age at marriage. More girls under 18 years of age are marrying now in the United States than were marrying at that age 10 years ago. Among boys of these ages the proportion hasn't changed.

Six out of every 100 girls from 14 to 17 years of age, a total of 249,000, were married; 15,000 more (0.3 percent) were already widowed or divorced in 1950. The figures for 1940 were 3.5 percent, or 168,484, married, and an additional 3,699 (0.1 percent) widowed or divorced.

Not as many boys as girls in this very young age group are marrying. In 1950, 11,000 boys from 14 to 17 years of age were married and in 1940, 15,249. In each of the 2 years these amounted to 0.3 percent of the boys in that age group.

From a BLS survey. Comparatively few social workers all over the country are devoting most of their time to services for children. In 1950 there were only 12,400 such workers in the United States in both private and public social agencies; 8,290 (two-thirds) were in State and local public agencies, operating in social-welfare agencies and institutions, in schools, and in courts. So reports the Bureau of Labor Statistics of the Department of Labor as a result of its study of salaries and working conditions in social work.

More than half of the workers, 6,643, were in public and private noninstitutional child-welfare programs, that is, programs that serve children chiefly in their own homes or in foster-family care. (The workers in this type of public program—the noninstitutional child-welfare workers—are, in general, the ones who carry out the child-welfare services for which the Children's Bureau grants funds to State public welfare departments.)

The graduate education of these workers and how much they were paid are also shown in the findings. Child-welfare workers in noninstitutional State and local agencies had had considerably more study in graduate schools of social work than had social-work employees primari-

ly responsible for public assistance, the report shows. Their graduate social-work schooling was also well above the educational accomplishment of the profession as a whole.

Forty-four percent of the workers in the public noninstitutional child-welfare programs had had a year or more of graduate social-work study, as compared with 27 percent for the social workers in all programs combined. But the workers in noninstitutional work in private agencies surpassed those in public agencies in professional education; that is, two out of three of the workers in private children's agencies had had at least a year of graduate study in social work.

The median annual salary for all persons in social-work positions was \$2,960.

Median annual salaries for all case workers and group workers was \$2,730.

For those in child-welfare programs, the median salaries were:

Noninstitutional child-welfare workers, \$2,790; institutional child-welfare workers, \$2,800; workers giving court service to children, \$3,030; school social workers, \$3,690.

The survey, in which the Bureau of Labor Statistics had the cooperation of the Federal Security Agency, the National Social Welfare Assembly, and the National Council on Social Work Education, reveals social work as a field of definitely low salaries.

Employment of students. More high school boys and girls are taking on jobs outside school hours, according to a recent report of the Bureau of the Census, based on a sample survey made in October 1950. At the beginning of the school year 1950-51 an estimated 1.6 million boys and girls 14 through 17 years of age who were enrolled in school were also employed, or about 400,000 more than a year earlier. Nearly a quarter of all the boys and girls of these ages in the United States who were attending school were either employed or looking for jobs in October 1950; a year earlier the proportion was about one-fifth. Only at the height of World War II has this proportion been higher — approximately one-third in April 1944.

A considerable number of the student workers 14 through 17 years old—226,000 out of a total of 1,613,000, or 1 in 7—were employed 35 hours or more per week; and 693,000, or 3 in 7, worked from 15 to 35 hours a week.

In the present period of rising employment opportunity, these facts suggest that school and community planning and sometimes advances in State child-labor legislation are essential to insure that young students do not take on so heavy a burden of employment outside school hours that they risk both health and school progress.

This census report deals with the school attendance of all workers under 25 years of age and includes information not only on age and hours of employment, but also on sex, major occupation groups, and unemployment.

The report is titled: *Current Population Reports: Labor Force, Series P-50. No. 32. June 22, 1951.*

Marriages and divorces. Marriages in the United States increased in 1950 for the first time since 1946, and divorces declined for the fourth consecutive year. These trends are shown by the preliminary figures of the National Office of Vital Statistics.

There were 1,669,934 marriages in the United States in 1950, an increase of 5.7 percent over the final figure for 1949 of 1,579,798 marriages. The marriage rate in 1950 was 11.0 (for every 1,000 of the population), and that for 1949 was 10.6.

The divorce total for 1950 was estimated at 385,000, compared with 397,000 in 1949, a decrease of 3.0 percent. The divorce rate for 1950 was 2.5 per 1,000 population; for 1949 it was 2.7 per 1,000.

UNICEF. Altogether 12 Latin American governments have contributed an approximate total of \$1,650,000 to the United Nations International Children's Emergency Fund. They are Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, Guatemala, Haiti, Peru, Uruguay, and Venezuela.

A total of 18 Latin American countries and territories are now receiving UNICEF aid out of an overall allocation of \$5,181,000 for the region. This international assistance is being used to help the countries to develop their own services for children and mothers; and in the conduct of large-scale campaigns against tuberculosis; diphtheria; whooping cough; malaria and other insect-borne diseases; and yaws and syphilis.

These countries and territories are: Bolivia, Brazil, British Hon-

duras, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, and Uruguay.

United Defense Fund. Watch for the seal of this fund when national appeals for money are made to finance community services for the armed forces and for defense-congested localities.

Organized by Community Chests and Councils of America and the National Social Work Assembly, UDF will screen, budget, and unite appeals within the circle of federated financing in all parts of the country. Thus, the Fund is seeking its support in cities that have community chests and in New York City, in which a limited joint appeal is made. Nearly 85 percent of the people that support private health and social work through gifts live in these cities.

UDF has two units. United Service Organization (USO reactivated from World War II days) has the following member agencies to give services to the armed forces: YMCA; YWCA; Salvation Army; National Jewish Welfare Board; National Catholic Community Service; National Travelers Aid Association; American Social Hygiene Association; and Camp Shows. United Community Defense Services has the following member agencies to give services to communities congested by defense production: YWCA; National Organization for Public Health Nursing; National Recreation Association; National Urban League; Child Welfare League of America; National Catholic Community Service; National Federation of Settlements; National Travelers Aid Association; and the American Social Hygiene Association.

The major appeal will be for services to the armed forces.

For a social-work paper. An award of \$500 will be made by a committee of the Alumni Association of the University of Pennsylvania School of Social Work for an original contribution in the field of social case work, or supervision, or social-work education. Deadline is December 31, 1951. For further information write to the Chairman of the Virginia P. Robinson Committee, Miss Mazie F. Rappaport, in care of Department of Public Welfare, 327 St. Paul Place, Baltimore 2, Md.

FOR YOUR BOOKSHELF

THE FIFTH INTERNATIONAL CONFERENCE OF SOCIAL WORK, PARIS, AUGUST 1950; preliminary notes. Published for the British National Committee by the National Council of Social Service, Inc. London, 1951. 49 pp. Copies can be had from the International Conference of Social Work, 22 West Gay Street, Columbus 15, Ohio, at \$1; special price for members of the International Conference, 50 cents.

Important papers were presented at the Fifth International Conference of Social Work, and a valuable exchange of experience in the various fields of social work took place. The report of its deliberations, which will be issued later in 1951, will form the basis of further study and action in many parts of the world. In the meantime the "preliminary notes" published in this booklet will act as an introduction to the fuller report.

SOCIAL WORK YEAR BOOK 1951; a description of organized activities in social work and in related fields. Edited by Margaret B. Hodges. American Association of Social Workers, New York, 1951. 696 pp. \$5.

Issued this year by the American Association of Social Workers instead of by its former publisher, the Russell Sage Foundation, the Social Work Year Book in 1951 maintains its high level of usefulness. We hear with deep regret that this is to be the final volume.

The eleventh issue of this biennial publication continues the original policy of presenting its subject matter so that it is a source of information to workers in other fields than social work. It is useful, for example, to social scientists, legislators, publicists, reference librarians, teachers, and boards of directors in many kinds of agencies, as well as to practitioners, administrators, and teachers of social work itself.

The Year Book does not confine itself to the field of social work. Because of the close relation existing between that field and several other fields, such as health, education, and religion, some discussion of subjects in these cooperating fields appear in the Year Book. The editors regard activities and

agencies as "related" if their practitioners cooperate with social workers in serving the same group of clients, as does the public-health nurse, or if their problems and objectives touch closely those of social work, as does housing and city planning. Topical articles on these related services are treated in the same way as articles on the fields of social work.

As in previous issues, the subject matter is presented in two parts, the first consisting of 73 signed articles by authorities on the topics discussed and the second consisting of directories of agencies. The four new topical articles added this year are all of interest to workers in the children's field; Youthful offenders; Family life education; Social work and the national emergency; and Informal education.

Looking over the list of topical articles to see how services to children are treated, we see such titles as Adoption; Child welfare; Foster care for children; Homemaker service; Juvenile and domestic relations courts; Juvenile behavior problems; Maternal and child health; and School health services. Some of the articles that include discussion of their subject matter as it relates to children are on: The blind; The deaf and hard of hearing; The crippled; Labor standards; Public assistance (in its section on aid to dependent children); Public health; Public welfare; Recreation; Social case work; Social group work; and Social insurance. The article on Canadian social work includes a discussion of family allowances granted for children.

Hilary Campbell

YOU AND UNIONS. By Dale Yoder. Science Research Associates, 228 South Wabash Avenue, Chicago 4, Ill. 1951. 48 pp. Single copies 40 cents, 3 for \$1. Quantity prices on request.

This little pamphlet, addressed to high-school students, contains a great deal of information on the labor movement. It gives a brief history of the labor movement in the United States and discusses union aims, collective bargaining methods, and union organization and government. Though directed to young people, it shows the relation of unions to all segments of the population. The pamphlet should stimulate teen-agers to learn more about labor unions.

Ione L. Clinton

CALENDAR

Aug. 27-31. National Council on Family Relations. Annual conference. Lake Geneva, Wis.

Aug. 31-Sept. 5. American Psychological Association. Fifty-ninth annual meeting. Chicago, Ill.

Sept. 3-7. Second International Poliomyelitis Conference. Copenhagen, Denmark.

Sept. 4-7. International Association of Governmental Labor Officials. Annual meeting. Seattle, Wash.

Sept. 5-7. American Sociological Society. Annual meeting. Chicago, Ill.

Sept. 6-11. National Conference of Catholic Charities. Annual meeting. Detroit, Mich.

Sept. 8-15. American Occupational Therapy Association. Thirty-fourth annual convention. New Castle, N. H.

Sept. 9-14. Fifth World Congress of the International Society for the Welfare of Cripples. Stockholm, Sweden.

Sept. 17-20. American Hospital Association. Fifty-third annual convention. St. Louis, Mo.

Sept. 30-Oct. 7—Christian Education Week. Twenty-first annual observance. Sponsored by the National Council of Churches of Christ, Division of Christian Education, 79 East Adams Street, Chicago 6, Ill.

REGIONAL CONFERENCES

American Public Welfare Association.

Sept. 6-8. Northeast States, Swampscott, Mass.

Sept. 20-22. West Coast States, Oakland, Calif.

Oct. 1-2. Southeast States, Nashville, Tenn.

Illustrations:

Cover and p. 10, Esther Bubley for Children's Bureau.

Pp. 3 and 4 Virginia State Department of Health.

P. 6, George Jones for Federal Security Agency.

P. 7, National Organization for Public Health Nursing.

THE CHILD

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AUGUST-
SEPTEMBER 1951

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A MESSAGE FOR "THE CHILD"

The Child is one of the most important means through which the Children's Bureau carries out its primary purpose of investigating and reporting on all matters pertaining to the welfare of children and child life. It began, in the first decade of the Bureau's history, as a mimeographed Weekly News Summary, prepared chiefly for the information of the Chief and members of the staff. In its present form it has reached a much larger audience. One of the most interesting tasks of my office has been the review of each number of *The Child* in manuscript form. In this review I have felt very close to the readers, the contributors, and the editor. Now as I leave my active connection with the Children's Bureau, I shall look to *The Child* to keep me closely in touch with the Bureau staff, and with the fellowship of people in our own and other countries who find it a source of inspiration and information.

As we look back over the years since the Children's Bureau was created we can see great accomplishments, but these gains have been accompanied by tremendous problems affecting all our people. Redoubled effort is necessary if the Bureau's final purpose, to help to assure for every child his fair chance in the world, is to be accomplished. May each number of *The Child* be a reminder to us all that the welfare of children is a test of our democracy a test which must be met if our Nation, in cooperation with other free peoples, is to cherish and apply more fully the values inherent in personal freedom, civic responsibility, and spiritual growth.

Katharine F. Lenroot
Chief, Children's Bureau

Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is \$1 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

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